Arizona Access To Recovery
CHOICES Program

Freedom From Drugs Through Freedom of Choice

Yavapai County Superior Court
Post Conviction Drug Court

Recovery Support Provider
Enrollment Application

Yavapai County Superior Court
Access to Recovery (ATR)
Recovery Support Provider Enrollment Application

To avoid confusion between clinical treatment and recovery support services, and to differentiate between the training and licensing requirement for clinical treatment and recovery support, Yavapai County Adult Probation will require a formal contract with clinical treatment providers and an applications process to serve as a service agreement with recovery support providers.

To participate as a Yavapai County ATR recovery support service provider, each applicant must complete a recovery support provider application. The following three (3) parts of the application must be complete for it to be processed:

Part 1 – General Applicant Information (SECTIONS A – I)

- ☐ All applicable questions are answered. If an item is not applicable, write N/A
- ☐ Each individual person providing services has completed, signed, and dated the attestation statement.
- ☐ Section I is signed and dated by an authorized individual, (i.e. Executive Director) on behalf of the agency or organization.

Part 2 – Organization Participation Agreement

- ☐ The provider participation agreement is signed and dated by an authorized individual, i.e. Executive Director.

Part 3 – Support Documentation

- ☐ License for the organization or program (if applicable).
- ☐ W-9 – Request for Taxpayer Identification Number for the organization or Social Security # for a Sole Proprietor.
- ☐ Current license, certification, and/or registration for each staff member who will be providing services under this agreement (if applicable).
- ☐ Documentation of liability insurance (if applicable).
- ☐ Background check documentation.

Once the application is complete, the application and support documents must be mailed to the Yavapai County Adult Probation Department. Please submit all documentation to:

Alexa Garcia,
Grant Program Manager
Yavapai County
Adult Probation Department
255 E. Gurley St. 2nd floor
Prescott, AZ 86301
Phone 928-777-7365
Email alexa.garcia@co.yavapai.az.us

Part 1 - General Application Information

SECTION A – Administrative Information

Instructions:

1. **Applicant Organization Name** – Provide the name of the agency or organization.

2. **Physical Address** – Provide the street, city, state, and ZIP code of the administrative office.

3. **Mailing Address** – If different than the physical address, provide the street or post office box, city, state, and ZIP code where mail is received.

4. **TIN/SSN** – Provide the tax identification number (TIN) for the agency/organization or the SSN fir a sole proprietor.

5. **Contact Name and Title** – Provide the name and title of the individual who is authorized to administratively represent the agency or organization.

6. **Telephone Number** – Provide the area code and telephone number where the administrative representative can be reached.

7. **Facsimile Number --** Provide the area code and fax number where the administrative representative can be reached.

8. **Email** – Provide the e-mail address where the administrative representative can be reached.

9. **Operating Structure --** Indicate what type of organization by checking the appropriate box or boxes. Complete Faith-Based information if organization is faith-based.

1. Applicant Name (Agency, Business or Organization)

_____

2. Physical Address (Street, City, State, ZIP Code)

_____

3. Mailing Address (if different (Street/P.O. Box, City, State, ZIP Code)

_____

4. Tax Id Number/SSN _____

5. Administrative Contact Name and Title_____

6. Telephone Number _____

7. Fax Number _____

8. Email _____

9. Please identify what type of agency/business (check all that apply)

- ☐ Not-for-Profit Organization
- ☐ For-Profit Corporation
- ☐ For-Profit Sole Proprietor
- ☐ State Agency
- ☐ Federal Agency
- ☐ Tribal Organization
- ☐ Tribal Program
- ☐ Community Organization
- ☐ Faith-Based*
- ☐ Recovery Community
- ☐ Other, Describe:_____

* If faith-based, please answer the following:

Check the following definition of a faith-based organization that best fits your organization:

- ☐ A religious congregation (church, mosque, synagogue, or temple); or
- ☐ An organization, program, or project sponsored/hosted by a religious congregation (may be incorporated or not incorporated); or
- ☐ A non-profit organization founded by a religious congregation or religiously-motivated incorporators and board members that clearly states in its name, incorporation, or mission statement that it is a religiously motivated institution; or
- ☐ A collaboration of organizations that clearly and explicitly includes organizations from the previously described categories

If the organization is a religious congregation, indicate the size of the congregation:_____

10. First Point of Contact Information (Name of the person that a potential client who is seeking ATR services would contact first)

_____
Name

_____
Phone Number

Section B – Fiscal Information

Instructions:

1. **Contact Name and Title** –Provide the name of the individual who is authorized to provide and receive payments, fiscal reports, and fiscal information. (i.e. payments, financial reports and financial records, etc.).

2. **Mailing Address** – If different than Section A, provide the street or post office box, city, state, and ZIP code where mail is received by the fiscal office.

3. **Telephone Number** – If different than Section A, provide the area code and telephone number for the fiscal office.

4. **Facsimile Number**– If different than Section A, provide the area code and FAX number for the fiscal office.

Who to Contact for Fiscal Information and Financial Reports:

1. Fiscal Contact Name and Title (if different)

_____

2. Mailing Address (if different (Street/P.O. Box, City, State, ZIP Code)

_____

3. Telephone Number (if different) _____

4. Facsimile Number _____

5. Email (if different) _____

Section C – Voucher Transactions

Instructions:

1. **Contact Name and Title** – Provide the name of the individual who is authorized to provide, receive and discuss voucher transactions and billing information.

2. **Mailing Address** – If different than Section A, provide the street or post office box, city, state, and ZIP code where mail is received by the billing office.

3. **Telephone Number** – If different than Section A, provide the area code and telephone number for the billing office.

4. **Facsimile Number --** If different than Section A, provide the FAX number.

Who to Contact for Voucher Transaction Questions, Billing for Services:

1. Voucher Transactions and Billing Contact Name and Title (if different)

_____

4. Mailing Address (if different [Street/P.O. Box, City, State, ZIP Code])

_____

3. Telephone Number (if different) _____

5. Facsimile Number _____

6. Email (if different) _____

Section D – Administrative Offices Hours of Operation

Instructions:

For each day of the week, provide the hours your administrative staff is available.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

General Instructions Sections E, F, G, H and I:

Some organizations have multiple programs or departments that may provide recovery support services. Each program, department, and location must separately provide the information requested in sections E, F, G, and H.

For Example, a community action agency may have multiple programs that could provide services, such as: health and wellbeing activities, nutrition and health management classes, recreation, parenting and skill-building and life skills classes, self-help groups, child care, transportation, mentoring, etc.

Tribal Umbrella: a tribe may have a substance abuse or behavioral health department that provides recovery support services in addition to clinical treatment. The tribe may also have a recreation department, a cultural division, a health department that provides health education in nutrition, health and wellness, chronic disease management, alternative medical interventions for stress management, a traditional healer on contract, etc. A Human Services department may provide parenting and life skills classes or family retreats. Cultural divisions may provide men's and women's circles sweat lodges, fasting camps or teaching circles. Each of these services, and others, can be considered recovery support for ATR clients. These recovery support services would be provided under the tribe's umbrella of services.

An individual or non-tribal business or agency could petition a local tribe to provide services under their "tribal umbrella" (this option would be individualized using a qualified service agreement) and is entirely up to the participating parties to negotiate. The idea is presented here as an option, especially for individuals in the recovery community who are not "in business" but who have skills to support recovery for their peers.

Services provided by employees of the tribe, as well as, services provided by individuals under contract with the tribe can be billed to the ATR project as long as they are provided to clients enrolled in the ATR program. **The resources from ATR cannot be used to supplant (replace) existing resources. The ATR dollars are intended to fill gaps in services, to expand or supplement existing services.**

Section E – Program/Department Information (If Applicable)

Instructions:

1. Program/Department Name – Provide the name of the program/department within your agency or organization that may provide service(s).
2. Contact Name and Title – Provide the name of the individual who is authorized to provide and receive information on behalf of the program/department.
3. Admissions Name and Title – Provide the name of the individual that the client would make the first contact with for admission.
4. Physical Address – Provide the street, city, state, and ZIP code where service(s) will be delivered.
5. Mailing Address – Provide the street or post office box, city, state, and ZIP code where mail is received by the program/department.
6. Telephone Number – Provide the area code and telephone number for the program/department.
7. FAX Number: Provide the area code and facsimile number for the program/department.
8. Email Address for the program/department.

Provide information for the program/department(s) that will provide service(s) (**Provide this information for <u>each department</u> that will provide services, pages 10-13)**

1. Program/Department Name _____

2. Administrative Contact Name and Title (if different)

_____

3. Program Admission Contact for Substance Abuse Clients (if different)

_____

4. Physical Address (Street, City, State, ZIP Code)

_____

5. Mailing Address (if different [Street/P.O. Box, City, State, ZIP Code])

_____

6. Telephone Number _____ 7. Facsimile Number _____

8. Email _____

Section F – Program/Department Services

Instructions:

Check the boxes of all of the services you offer. Add any others not listed that you provide. **(Provide this information for <u>each department</u> in your organization or agency that will provide services).**

1. Identify the gender and ages of clients your program/department serves

Gender: ___ Male ___ Female

Age Range: _____ Adolescents age _____ to _____
_____ Adults age _____ to _____

2. Identify the service(s) your program provides (Check all that apply)

Please indicate if you provide the following services by checking the boxes under the population served category. Please attach copies of curricula outlining the services, if applicable.			
	Population Served		
Type of Recovery Support Service	Services to be Delivered Under this Application Fee Charged to the General Public		Fee Assessed to the General Public
The rates listed on this table should indicate the amount per unit of care. Please define unit of care (i.e. hour, month, day, session, etc…)	Offered and will provide services to Choices Program	Rate Charged to ATR Program by Unit	
Transportation: (to and from treatment, RSS activities, employment, etc.): Commuting services are provided to clients who are engaged in treatment- and/or recovery support-related appointments and activities and who have no other means of obtaining transportation. Forms of transportation services may include public transportation or a licensed and insured driver who is affiliated with an eligible program provider.			
Child care: These services include care and supervision provided to a client's child(ren), less than 14 years of age and for less than 24 hours per day, while the client is participating in treatment and/or recovery support services. These services must be provided in a manner that complies with State law regarding child care facilities.			
Peer-to-peer services, mentoring, coaching: Mutual assistance in promoting recovery may be offered by other persons who have experienced similar substance abuse challenges. These services focus more on wellness than illness. Mentoring and coaching may include assistance from a professional who provides the			

client counsel and/or spiritual support, friendship, reinforcement, and constructive example. Mentoring also includes peer mentoring which refers to services that support recovery and are designed and delivered by peers----people who have shared the experiences of addiction recovery. Recovery support is included here as an array of activities, resources, relationships, and services designed to assist an individual's integration into the community, participation in treatment, improved functioning or recovery			
Spiritual and faith-based support education: These services assist an individual or group to develop spiritually. Activities might include, but are not limited to, establishing or reestablishing a relationship with a higher power, acquiring skills needed to cope with life-changing incidents, adopting positive values or principles, identifying a sense of purpose and mission for one's life, and achieving serenity and peace of mind. Faith-based services include those provided to clients and using spiritual resources designed to help persons in recovery to integrate better their faith and recovery. Such services are usually provided in a religious or spiritual setting by spiritual leaders or other staff who are knowledgeable about the spiritual values of the community and are equipped to assist individuals in finding spirituality. Services include, but are not limited to, social support and community-engagement services, faith, or spirituality to assist clients with drawing on the resources of their faith tradition and community to support their recovery; mentoring and role modeling; and pastoral or spiritual counseling and guidance.			
Life skills: Specific instruction to clients in order that specific skill sets may be improved or developed.			
Employment Services and Job Training: These activities are directed toward improving and maintaining employment. Services include skills assessment and development, job coaching, career exploration or placement, job shadowing or internships, résumé writing, interviewing skills, and tips for retaining a job. Other services include training in a specific skill or trade to assist individuals to prepare for, find, and obtain competitive employment such as skills training, technical skills, vocational assessment, and job referral.			
Family/Marriage Education Services provided to engage the whole family system to address interpersonal communication, codependency, conflict, marital issues and concerns, parenting issues, family reunification, and strategies to reduce or minimize the negative effects of substance abuse on the relationship within the family system.			
Indigenous Healing: These services are designed to address emotional and/or behavioral issues which impact functional ability. Services are provided by qualified and tribe recognized traditional healers.			
Housing Assistance and Services (transitional housing, sober housing, etc.)These services include transitional housing, recovery			

living centers or homes, supported independent living, sober housing, short-term and emergency or temporary housing, and housing assistance or management. These services provide a safe, clean, and sober environment for adults with substance use disorders. Lengths of stay may vary depending on the form of housing. This assistance also includes helping families in locating and securing affordable and safe housing, as needed. Assistance may include accessing a housing referral service, relocation, tenant/landlord counseling, repair mediation, and other identified housing needs.			
Education Services Educational Services include, but are not limited to: • GED Preparation. • Instruction and support activities to prepare individuals to pass the high school equivalency examination (GED) • Adult Basic Education Services • Instruction in basic reading, writing and/or arithmetic skills to individuals performing at or below appropriate grade level.			
Alcohol/Drug Testing: Monitoring drug use through urinalysis or other objective methods, as part of treatment or criminal justice supervision, provides a basis for assessing and providing feedback on the participant's treatment progress			
Family Support Services: This service involves face-to-face interaction with family member(s) and is directed toward restoration, enhancement or maintenance of the family function to improve the family's ability to effectively interact and to care for the youth in the home and community. The service may involve support activities such as assisting the family in developing skills to effectively interact and manage the youth, understand the causes and treatment of behavioral health issues, understand and utilize the system, and plan long term for the client and the family.			
Employment Services: This service provides job placement for individuals who may not otherwise be employed in other traditional settings. The provider must complete an employability assessment, individual service and job development plan with participants. This service may include short-term job training, job coaching and mobility training. The provider must have in-person contact with participants not to exceed twice weekly.			
Additional Services: A signatory may request additions to the above approved services by completing the Request for Service Approval document provided.			

Hours of Operation

Main location: Hours of Operation for Client Services:						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Other location(s) (list addresses for other locations):						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Other location(s) (list addresses for other locations):						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Other location(s) (list addresses for other locations):						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Section G– Program/Department License

Instructions:

Complete only if services provided are required to have a license. If licensing is not applicable, place NA in the table. If the program/department within an agency or organization is a licensed program/department, provide the information requested in section G. A copy of the license must be provided with the application. If a program/department has more than one license or is accredited make a copy of the additional licenses or proof of accreditation and submit it with this application. Many recovery support services will not be licensed.

Provide Licensing Information for Each Program/Department within an agency or organization that will Provide Service(s)

Program/Department	Licensing Agency Name	Licensing Type	Licensing Number	Effective Dates mm/dd/yy – mm/dd/yy

Section H – Staff Member Information

Instructions:

Provide the credential information for each individual staff member who will provide services. A copy of each individual's license, certification, or registration must be provided with the application (if applicable: recovery support providers may not have written credentials). If a program has more than two (2) staff members, make a copy of this section (pages 13-17) and submit for each individual.

Name of Provider Agency or Organization:_____

Name of Program: _____

Provide Credential Information for **Each Individual** staff person who will provide service(s) **(Attach additional sheets as necessary.)**

---

1. Individual Staff Member Name

_____

2. Education/Credentials & Specialty

_____

3. Date of Birth _____4. Email_____

5. License/Certification Board Name

_____

6. License/Certification Number _____

7.License/Certification Dates (Effective) _____(Expiration)_____
mm/dd/yy mm/dd/yy

Services the staff member is qualified and/or licensed to provide:

Recovery Support Services

- ☐ Family Services (Marriage Education, parenting and child development services.)
- ☐ Child Care Services
- ☐ Employment Services
- ☐ Pre-Employment Services/ Job Readiness
- ☐ Employment Coaching
- ☐ Individual Services Coordination (Case Management)
- ☐ Transportation Services
- ☐ HIV/AIDs Services
- ☐ Transitional Drug Free Housing Services (Limits Apply)
- ☐ Other Case Management
- ☐ Special Need Fund
- ☐ Peer Mentoring/Recovery Coaching
- ☐ Pastoral Guidance
- ☐ Traditional Healing Services
- ☐ Spiritual Support Services
- ☐ Group/Peer Support Services/Self Help Support Groups
- ☐ Individual/Peer Support Service
- ☐ Daily Living Skills/Group
- ☐ Indigenous Language Recovery/Expression
- ☐ Storytelling/Cultural Teaching
- ☐ GED Preparation
- ☐ Educational Tutoring
- ☐ Other Education Services
- ☐ Alcohol- and Drug-Free Social Activities
- ☐ Physical Fitness and Well-Being Activities
- ☐ Stress Management
- ☐ Nutritional Management
- ☐ Information and Referral
- ☐ Other Peer to Peer Recovery Support Services
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

Please Describe Any Specialty Services that your program provides:

Comments

Section H-a – Staff Member (Individual Provider) Attestation Questions (Each Individual Staff Member)

Must be completed, signed, and dated by each individual staff member providing recovery support services.

Each individual staff person/provider is required to complete, sign, and date this form. For programs that have more than one staff person, please make a copy of this form for each provider. An application will not be considered complete unless a completed attestation question form is submitted for each person who is identified to provide services in the provider application.

Please answer "YES" or "NO" to the questions below. If you answer "YES" to questions A through C, please provide a full explanation on a separate sheet of paper referencing the section number.

A. Have you ever been convicted of any crime (other than a minor traffic violation)?
___Yes ___No If yes, give particulars on a separate sheet of paper.

B. Do you presently use any drugs illegally?
___Yes ___No

C. Have you had a criminal background check within the last 12 months? Is it on file with your organization or agency?
___Yes ___No

I hereby affirm that the information submitted in this Section H -a (Provider Attestation Questions) and any attached addendums is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that omissions and misrepresentations may result in denial of my application or termination of my privileges as a provider under ATR.

_____
Print, Staff Person/Provider Name

_____
Signature Date

Section I – Certification

Instructions:

Section I is signed and dated by an authorized individual (i.e. Executive Director, business owner) on behalf of the agency or organization.

1. I declare the statements on this application are correct to the best of my knowledge.

2. I am authorized to sign this application on behalf of the named applicant.

Signature _____ Title _____
(Stamped signature is not acceptable)

Date _____

Part 2 - Organizational Participation Agreement

Must be signed and dated by an authorized individual on behalf of the organization. To participate as an ATR provider, our organization, as the provider of services agrees to:

1. Not charge ATR for services paid for by other funding sources. (Examples of such funding sources are private insurance, Medicaid, Medicare, or State Block Grant funds administered by the Regional Coordinating Agency that your organization has a contract with)(ATR Funds are the payer of last resort with the exception of Indian Health Services and Tribal Resources. (CFR 42 136.61) Tribal resources pooled with Indian Health Services resources are covered by the rules established for Indian Health Services funds). **ATR must supplement, not supplant, other funding sources**.

   Not charge a client for the following:
   - Services for which the provider is entitled to payment from ATR;
   - Services for which the provider could have been entitled to payment from ATR had the provider complied with certain procedural requirements;
   - Services for which the provider could have been entitled to payment from ATR had the provider not been charged with a reduction or denial in payment as a result of quality review; and
   - Services rendered during a period in which the provider was not authorized to provide services.

2. Comply with the applicable provisions related to ATR policy.

3. Accept the ATR allowable payment combined with any cost share or other health insurance amounts payable by, or on behalf of, the client, as full payment for authorized services.

4. Collect from the client those amounts that the client has a liability to pay for.

5. Allow ATR to review the service records of clients in accordance with applicable tribal, state and/or federal law.

6. Cooperate fully with utilization and quality management reviews conducted by ATR.

7. Obtain authorization via a voucher from ATR before rendering services.

8. Maintain service and other records related to clients for whom payment was made for services rendered by the provider or otherwise under arrangement, for a period of 7 years from the date of service.

9. Maintain service records that document the services provided to clients.

10. Notify ATR within five (5) business days when a client's eligibility status has changed.

11. Notify ATR immediately of suspected fraud and abuse and notify ATR immediately if either the provider or one of the provider's employees becomes excluded from participation in federal programs.

12. Notify ATR immediately when an employee who serves as a provider is no longer employed by the organization or their eligibility status changes.

13. Not use ATR program funds for clinical research involving human subjects, and not enroll clients in clinical research involving human subjects.

14. Maintain professional liability insurance.

15. Provide quality services within the appropriate standards of practice for each provider's profession.

16. Meet all ATR reporting requirements.

17. Agree to provide staff release time for core competency trainings related to ATR.

18. The agency/organization agrees and understands that agents of the ATR will conduct random audits and may inspect the premises, review agency, personnel and client records, observe program operations, and interview employees and clients associated with the program(s).

19. Meet future requirements established by ATR. (Any change in ATR requirements will be made in the form of a written amendment to this agreement).

20. Align current billing & accounting practices with electronic voucher system: orient accounting staff to voucher payment protocols.

21. Ensure that current program computer technology and internet connections are compatible and can support access to the ATR website. (Minimum requirements are DSL or high speed internet connection. Dial up connections are not adequate to run web based applications with the level of reliability necessary for this project.)

I declare that the statements on this application are correct to the best of my knowledge.

I am authorized to sign this application on behalf of the named applicant.

The ATR program agrees to make this agreement effective until terminated by either party. The effective date shall be the date on the application acceptance letter.

_____

Print, Agency/ Organization Name

_____

Print, Authorized Signer's Name Print, Authorized Signer's Title

_____

Signature, Authorized Signer's Name Date
(Stamped signature is not acceptable)

Part 3 -- CHECKLIST FOR ATR APPLICATION – RECOVERY SUPPORT	
	Completed Application/Completed Checklist
	In addition to the documentation below, please submit this completed checklist and the provider application. Please indicate that you have included the documentation by placing an "X" in the box below the number. If you will not be submitting one of the documents, place an "NA" in the box below the number. Do not leave any items on the checklist or questions on the application blank. **Only completed applications will be reviewed.**
1.	**Accreditation, License(s) for Organization (If Applicable)**
	Copy of any appropriate state or tribal license(s) to provide the services offered. (If applicable)
2.	**List of Individuals Providing Recovery Support Services**
	Provide information for each individual staff person who will provide services. A copy of each individual's license, certification, or registration. (If applicable)
3.	**Criminal Background Check**
	Certification that each individual in the agency or organization who has client contact has a recent (within 12 months) background check on file and available for audit. Anyone having client contact must have no prior convictions for child abuse or felony firearms charges.
4.	**Professional, Business Liability or Malpractice Insurance**
	Provide a copy of the agency's professional, business or malpractice insurance.
5.	**IRS Form W9**
	Completed and signed W9 form containing TIN or Social Security # for a Sole Proprietor
	INCLUDE ALL REQUESTED DOCUMENTS

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